

**MEDICAL BOARD OF CALIFORNIA****LICENSING PROGRAM**

2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX: (916) 263-2567
www.mbc.ca.gov



APPLICATION CHECKLIST FOR REGISTRATION AS A DISPENSING OPTICIAN (RDO)

Prior to filling out the application, please review [California Business & Professions Code sections 2550-2559](#) as they pertain to a RDO.

- ☐ \$75 registration fee. (Make checks payable to Medical Board of California.)
- ☐ Most current application completely filled out, signed and notarized.
- ☐ If applying as a corporation, Articles of Incorporation and a list of officers have been included.
- ☐ If Change of Owner, ensure cancellation form has been completed by previous owner and included with your application.
- ☐ Contact/liaison's NAME, phone number, and address - preferably someone at the store location. Corporations using headquarter employees as liaisons, please note: certificates, renewals, etc. are sent to the store's address of record (business location) - **no exceptions**.

Tips:

- Corporations, etc. filing for more than one new store must submit the requested items for EACH store location.
- Allow 8 weeks for review of a **COMPLETED** application - you will be notified in writing if any items are needed.

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**APPLICATION FOR REGISTRATION AS A DISPENSING OPTICIAN**

Please **READ** all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application. A separate application is required for each business location.

Registration is not transferable. Previous owner must complete a Cancellation of Certificate form prior to a new registration being approved.

1. Complete business name under which you will be doing business:			
2. Complete Business Address:			
3. Telephone/Fax Number:	Telephone: ()	Fax: ()	
4. Do you have any other Registered Dispensing Optician locations or pending applications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below.			
Business Name	Registration #	Complete Business Address	Telephone #
5. The applicant is: (Check only one box)	<input type="checkbox"/> Individual (Sole Proprietor) <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (Attach a copy of the articles of incorporation and a list of officers)		
6. Social Security Number or Federal/Taxpayer ID Number:			
7. The business will be filling prescriptions for (check all that apply): <input type="checkbox"/> Spectacle Lens <input type="checkbox"/> Contact Lens			
Name, address and registration number of each person who is responsible for overseeing the fitting and adjusting:			
Name	Address	Registration #	
8. Name, address, and telephone number of the person who is currently designated to handle customer inquiries and complaints:			
Name	Address	Telephone #	

The Division of Licensing of the Medical Board of California requests this information. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for registration per Section 2552 of the Business and Professions Code, which authorizes the collection of this information. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental or law enforcement agencies.

Disclosure of your Social Security Number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Corporations are exempt from this requirement. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

BOTH PAGES OF THIS FORM MUST BE COMPLETED

9. **FOR INDIVIDUAL OR PARTNERSHIP:** Information below to be completed by each owner.

a. Name _____ Address _____

Signature _____ Title _____ Date _____

b. Name _____ Address _____

Signature _____ Title _____ Date _____

FOR CORPORATIONS: Information below to be completed by the corporation president or secretary.

I am an officer of _____ (Complete name of corporation)
and such, make the declaration below for and on behalf of said corporation.

Name _____ Title _____

Corporation Address _____

Signature _____ Date _____

10. **Applicant's Declaration/Signature and Notary** (To be completed in the presence of a notary by an owner/officer named above.)

I, _____, being first duly sworn upon his/her oath deposes and says:
(PLEASE PRINT FULL NAME OF APPLICANT)

that I declare under penalty of perjury under the laws of the State of California that: (1) the business described herein will not advertise the furnishing of, or furnish, the services of a refractionist, an optometrist, or a physician and surgeon; directly or indirectly employ or maintain on or near the premises used for optical dispensing, a refractionist, an optometrist, a physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes (B&P § 2556), (2) the business described herein will not have any membership, proprietary interest, co-ownership, landlord-tenant relationship, or any profit sharing arrangement in any form directly or indirectly with an optometrist (B&P § 655), (3) the business described herein will not fill any prescription issued by a physician and surgeon who has any proprietary interest, or has designated or arranged for any other person to have any proprietary interest in the business described herein (B&P § 2553.6), (4) the business described herein will not have any membership, proprietary interest or co-ownership in any form with a physician and surgeon to whom patients, clients or customers are referred or any profit-sharing arrangement (B&P § 654).

Further, that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury under the laws of the State of California, that all of the information contained herein and attached thereto are true and correct. I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A REGISTRATION.

SIGNATURE OF APPLICANT: _____
(PLEASE SIGN FULL NAME)

Sign and Sworn before me this _____ day of _____, _____ at _____, California.
(month) (year) (city)



Signature of Notary Public

Address

My commission expires: _____